INSTRUCTIONS FOR NIH-546-3 SEDATION WORKSHEET

Privileged Physician/Dentist/Nurse Practitioner/Physician Assistant

Preprocedure Assessment:

- complete top section of form and sign "Practitioner Signature/Title" and enter date and time
- on reverse side of form under "Presedation", enter vital signs
- complete the pre-procedure pain score section

Intraprocedure Documentation:

- order appropriate medications to be administered
- remain with the patient for the entire procedure

Postprocedure Assessment:

- practitioner must remain in the Clinical Center until the patient has met all applicable "Discharge Criteria"
- print name of practitioner in "Practitioner Responsible for Recovery Period"
- complete the post-procedure pain score section

Registered Nurse

Intraprocedure Documentation:

- check vitals and record every five minutes
- administer medications as ordered and document on the Sedation Worksheet and per unit policy
- document any adverse events, IV fluids, patient response, etc.
- sign each line of assessment (or sign and then initial subsequent assessments)

Postprocedure Assessment (Recovery):

- perform continuous monitoring by direct visualization; vital signs to be recorded every 15 minutes until recovery criteria are met (use the NIH-546-4 Sedation Worksheet: Continuation Sheet if not enough space for documentation)
- complete the "Postsedation Score":
  ADM = admission to the recovery area
  Interim = any point during which the patient is being recovered that criteria may have changed
  DISCH = the point in time when the inpatient has achieved a total discharge score of 9 or greater and the outpatient has achieved a total discharge score of 10 and recovery monitoring can be discontinued
- ensure that all applicable criteria have been met and documented prior to discontinuation of recovery monitoring or discharge
- should the patient require pain medication or a reversal agent, the following standards should apply:
  - an additional 30 minutes of recovery monitoring from the time of administration of an analgesic agent
  - 90 minutes from the time of administration of Naloxone or Flumazenil
- sign "RN Signature" and enter date and time to document recovery from sedation

MEDICAL RECORD | Sedation Worksheet

PREPROCEDURE ASSESSMENT:

Procedure: _____ Procedure Location: _____

Age: _____ Weight: _____ (kg) Allergies: _____

Current Medications: _____

Pertinent Medical and Surgical History: _____

Vital Signs (baseline)	HR	RR	BP	Cap Refill (peds)	Temp	LOC* (see below)	O2 Saturation/FiO2

IV Access	Site and gauge:	*__Level of Consciousness:__ **(0)** unconscious, not responding; **(1)** arousable on calling, sedated; **(2)** fully awake

Physical examination:

☐ Physical Exam in current Progress Notes

ASA Classification Status

- ☐ I Normal healthy patient
- ☐ II Patient with mild systemic disease
- ☐ III Patient with severe systemic disease
- ☐ IV Severe systemic disease that is a constant threat to life
- ☐ V Moribund patient

Airway Evaluation

Mouth Opening	☐ Good	☐ Adequate	☐ Poor
Neck flexion/extension	☐ Good	☐ Adequate	☐ Poor
Thyromental distance	☐ Good	☐ Adequate	☐ Poor
Known Difficulties	☐ No	☐ Yes	

If Yes, Describe:

Laboratory Values (if applicable)	Sodium	Potassium	Glucose	WBC	Hgb	Hct	Platelets	PT	PTT

☐ NPO as per policy guidelines

☐ Informed consent document for procedure signed and in chart

☐ Procedure teaching performed

☐ Patient or responsible adult verbalizes understanding of teaching

☐ Responsible adult available for discharge of outpatient

Pre-sedation Evaluation: An assessment was completed immediately prior to the procedure, and the patient was confirmed to be an acceptable candidate for anesthesia/sedation: *(pre-sedation vital signs on reverse)* ☐ Yes ☐ No

I have explained the risks and options of sedation to this patient: ☐ Yes ☐ No

Responsible Practitioner Signature/Title _____ **Date:** _____ **Time:** _____
(MD, DMD, DDS, CRNP, PA Only)

INTRAPROCEDURE DOCUMENTATION:

See next page for intraprocedure documentation flowsheet

POST PROCEDURE ASSESSMENT:

POST SEDATION SCORE			**ADM**	**Interim**	**DISCH**
Activity	Able to move 4 extremities	(2)			
	Able to move 2 extremities	(1)			
	Able to move 0 extremities	(0)			
Resp	Able to breathe deeply and cough freely	(2)			
	Dyspnea or limited breathing	(1)			
	Apnea	(0)			
Circ	BP ± 20% pre procedure level	(2)			
	BP ± 20 - 50% pre procedure level	(1)			
	BP ± 50% pre procedure level	(0)			
LOC*	Fully awake	(2)			
	Arousable on calling, sedated	(1)			
	Unconscious, not responding	(0)			
0_2sat	>94% on room air or baseline FiO_2	(2)			
	Needs O_2 to maintain >90%	(1)			
	<90% even with supplemental O_2	(0)			
		Total Score:			

Total score under the Discharge column must be 9 or greater for inpatients, 10 for outpatients

PRACTITIONER RESPONSIBLE FOR RECOVERY PERIOD (Print):
MD, DMD, DDS, CRNP, PA Only:

_____

POST-PROCEDURE PAIN SCORE DISCHARGE: _____

Pain Tool Used: _____

DISCHARGE CRITERIA FOR ALL PATIENTS:

- o Airway reflexes intact
- o Bleeding is controlled
- o Hydration is adequate
- o Minimal or no nausea
- o No emesis for ≥ 20 min

RN Signature: _____

Date: _____ **Time:** _____

ADDITIONAL DISCHARGE CRITERIA FOR *OUTPATIENTS*:

- o Responsible adult present and provided with printed instructions
- o Pain free or mild pain controlled by oral medications
- o Drinks fluids or only minimal nausea without emesis
- o Ambulatory ability at baseline
- o Has voided or unable to void but comfortable
- o Vital signs stable for one hour

RN Signature: _____

Date: _____ **Time:** _____

Date:_____ Time Procedure Start:_____ Time Procedure End:_____

Procedure:_____

Pre-Procedure Pain Score: _____ **Pain Tool Used:** _____

TIME	MEDICATION (Drug, Dose, Route)	HR/RR	BP/CAP REFILL	FiO_2/ O_2Sat	LOC*	Comments	Signatures
Pre-Sedation							

***Level of Consciousness:** **(0)** not responding, unconscious; **(1)** arousable on calling, sedated; **(2)** fully awake